2306 SE Cesar E Chavez Blvd, Portland, OR 97214
(503) 239-8430 Fax (833) 989-2221

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full Name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: _____

Cell Phone: _____ Work Phone: _____

Email address: _____

Marital Status: Married Single Widowed Divorced Partnered

PATIENT EMPLOYER

Occupation: _____

Employer: _____

Employer Address: _____

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INSURANCE INFORMATION:

Insurance Company Name / Claims Address: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ID Number: _____

Group Number: _____ Relationship to Patient: _____

IN CASE OF EMERGENCY

Name: _____

Phone Number: _____ Relationship to Patient: _____

PATIENT HISTORY:

Are You: Right-Handed: ☐ Left-Handed: ☐ Both: ☐

Height: _____ Weight: _____

Blood Thinners you are currently taking: _____

Do you have a pacemaker: _____

Are you taking any weight loss medications (e.g., Ozempic): _____

Medication Allergies: _____

PORTLAND HAND CLINIC

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Medications you are taking: _____

_____

Preferred Pharmacy: _____

Tobacco products: Y / N Alcohol use: Y / N Other drug use: _____

Referring Doctor or Individual: _____

Date of Injury/Onset of Symptoms: _____

Which Side is Involved: Right: ☐ Left: ☐ Both: ☐

Describe in as much detail as possible the circumstances of your injury or problem. How did it occur? When did pain or swelling occur? Was it at work? Etc.

_____

_____

_____

_____

_____

_____